

***Envisioning Solutions:
Creative Partnerships for the
Future of Health Care in Canada***

Québec, QC
April 30, 2003

Symposium Proceedings

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Association of Canadian Medical Colleges
Association des facultés de médecine du Canada

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Program

Morning Plenary: Addressing Mutual Goals and Needs

Chair: Dr. Michel Brazeau
Chief Executive Officer, The Royal College of Physicians and Surgeons of Canada

Introduction and Welcome

Dr. Robert Woollard
Royal Canadian Legion Professor and Head, Department of Family Practice,
University of British Columbia

The Task of National Policy Making

Mr. Ian Shugart
Assistant Deputy Minister of Health, Health Canada

The Task of Provincial Service Delivery

Dr. Thomas Ward
Deputy Minister of Health, Government of Nova Scotia

A Framework for Action and Tools to Measure Progress

Dr. Charles Boelen
International Consultant (health system and personnel)
Former coordinator of the Program for Human Resources in Health, WHO

The Challenges of Communicating to the Public on Health Reform

Mr. Douglas Griffiths
MLA, Government of Alberta
Speaking on behalf of The Honourable Gary Mar
Minister, Health and Wellness, Government of Alberta

Work Groups: Addressing Mutual Goals and Needs

Participants addressed the following questions:

1. Given challenges such as the geography of the country, its diverse cultures and variety of social issues, what do our marginalized populations (Aboriginal, poor, inner city, rural, etc.) need from medicine? From health policy? From the Academy?
2. How do current patterns of training, research, health policy and models of care address community needs?
3. What current gaps can be narrowed through creative partnerships between the Academy, communities, policy makers and practitioners?
4. How can collaboration between policy makers, health professionals, academic institutions, communities and health managers be improved and/or made explicit?

Plenary feedback and dialogue with panel members/discussion

Group Facilitators/Rapporteurs:

Dr. Oscar Casiro

Associate Dean, UGME, University of Manitoba

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V-doyen à la communauté ; V-doyen, UGME, Université de Sherbrooke

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Royal Canadian Legion Professor and Head, Department of Family Practice,
University of British Columbia

Afternoon Plenary: Developing Creative Partnerships and Taking the Next Steps

Chair: Dr. Calvin Gutkin

Executive Director, The College of Family Physicians of Canada

What the Community Needs From its Professional, Academic and Political Partners

Minister Sharon Carstairs

Senate of Canada

What Provincial Ministers Need and What They Bring to the Partnership

The Honourable Dennis Furlong

Minister of Education, Government of New Brunswick

What Practicing Physicians Need and What They Bring to the Partnership

Dr. Dana Hanson

President, Canadian Medical Association

What a Socially Responsible Academy Needs and What It Brings to the Partnership

Dr. Abraham Fuks

Dean, Faculty of Medicine, McGill University

President, Association of Canadian Medical Colleges

Closing Plenary: Summary and Next Steps in Partnership Building

Chair: Dr. T. Jock Murray

Director/Professor of Medical Humanities, Dalhousie University

Through a reflective dialogue the meeting was tasked with outlining the broad elements of a plan for creative partnership building and an identification of the next steps in bringing that plan to life.

- What must be done? (Planning Process)
- Who must do it? (Planning Process)
- How will it be done? (Structure)
- When will it be done? (Time Lines)
- How will we feed back? (Reporting)

An Overview of the Symposium with Next Steps

On April 30, 2003, the Association of Canadian Medical Colleges (ACMC) sponsored a national symposium, with other key stakeholders, on the social accountability of medical schools. The purpose of the symposium was to build a shared vision and action agenda around the concept of social accountability. The specific objectives of the symposium were to:

- Build a shared vision of the various roles of the medical schools and their partners in meeting the needs of the community by exploring the predisposing and enabling factors which will allow that vision to be expressed; and
- Build a national framework of committed partnerships to allow the municipal/regional/provincial partnerships to network for the development and demonstration of a national agenda on social accountability.

To that end, 54 participants gathered, including federal and provincial policy makers, academics, health professionals and their organizations, researchers and research organizations, health managers, residents, students and community organizations. Participants interacted with prominent plenary speakers and worked in small groups to address focused questions. Participants left the day with a commitment to moving forward with a plan of action.

Background to the Symposium

The academic medical community and Canada's medical schools have a function in three major arenas: creating new knowledge to serve the system (research); the transmission and application of effective knowledge through the creation of effective medical professionals (education); and the provision of clinical services. The ACMC has recognized that those tasks are most responsibly completed if academic medicine works closely with governments, professional health organizations and communities to define and respond to the priority health needs of Canadians.

In order to work towards that goal, Health Canada, in collaboration with the ACMC, convened a Steering Committee on Social Accountability of Medical Schools in 2000. This group produced a vision paper for Canadian medical schools, based on the WHO concept of social accountability of medical schools (www.acmc.ca/issues.htm). Subsequently, ACMC has been developing strategies to raise awareness of the concept and identifying innovative projects that demonstrate that they meet the need of the communities served by the medical schools. This symposium is one of many activities being undertaken at present. In addition, the theme of the 2003 ACMC/CAME Annual Meeting was social accountability – and in its two plenary sessions social accountability of the Academy in the community and in the laboratory was addressed.

The ACMC believes that the future of health care in Canada can and must be shaped by the concerted action of those who care deeply and act wisely in service to that future. They recognize that no single social institution bears full responsibility for design, development and maintenance of this most fundamental of Canadian values. Preparing

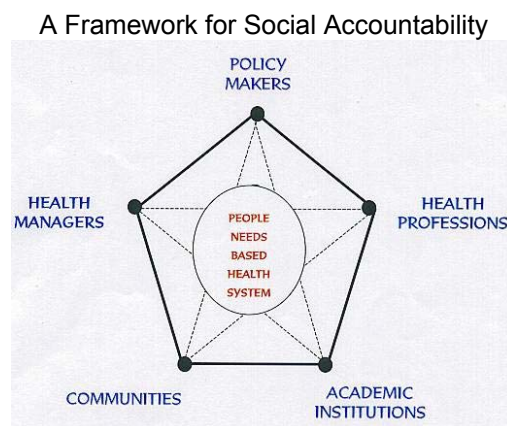
for fundamental change, the best outcome is likely to result when all interested parties can work together to define their individual roles and their collective responsibilities. Academic medicine in Canada wishes to foster and participate in a process that chooses a future that embraces an enduring collaboration with communities and governments in response to the needs of the society.

At the Symposium, plenary speakers were invited to present their thoughts on critical issues – a framework for action, the roles and responsibilities of all partners and the context of social accountability and health care. Participants addressed questions in small groups that focused on identifying ways of meeting societal needs through training, research, health policy and models of care; identifying gaps and ways to decrease them through creative partnerships and finding ways to collaborate more effectively.

The Symposium Discussion

Through the plenary speakers and the work of the participants in small groups, a number of themes relating to social accountability recurred and were embraced.

First, participants identified the need for a **framework** for action. This framework – and all subsequent actions – should be based on societal needs. Participants embraced a basic framework for social accountability presented by Dr. Charles Boelen. The framework is centered upon the needs of the community, includes all necessary partners, and illustrates the relationships between the partners. The framework is a pentagram, where each tip of the pentagram represents one of the partners – policy makers, health managers, health professions, communities and academic institutions. Dr. Boelen elaborated on the potential challenges in bringing this framework to life – the fragmentation of our health care system; institutional change; and creating sustainable partnerships.



All participants agreed that **sustainable partnerships** formed the basis of social accountability. There was a great deal of discussion regarding what constitutes *real partnerships*. For example, Dr. Ward helped participants articulate some common elements to real partnerships – equality between members, mutual respect, a common vision, exchange of purpose, shared values, joint accountability, the right to say no, and absolute honesty. Dr. Fuks cautioned participants that more than just concepts of partnerships are needed – there is a need to identify mechanisms for partnership development. Dr. Hanson supported the establishment of the proposed Canada Health

Council as having tremendous potential to enable health professionals, governments and Canadians to forge meaningful partnerships that will sustain the health care system in the long run. Symposium participants articulated the roles and responsibilities of the partners at a variety of levels. It was agreed that partnerships need to be forged at all levels – locally, provincially or regionally, and nationally. Therefore, the framework for social accountability – the pentagram – is relevant at all three levels.

Values were a recurrent theme of the Symposium’s discussions. Values were seen as central and foundational to the whole concept of social accountability. Values were discussed in a variety of contexts. Dr. Boelen described fundamental values of social accountability – quality, equity, relevance and cost-effectiveness. Mr. Ian Shugart reminded participants that Canadians are strongly attached to the fundamental values of the Canada Health Act, being “social equity in the health system that guarantees access to medically necessary services on equal terms and conditions”. Symposium participants repeatedly emphasized the need for academia to demonstrate the value of social accountability through its reward system.

Participants identified social accountability as an overarching, all encompassing phenomenon – a **cultural identity**. It is not to be seen as an add-on; a ‘project’, a module or a ‘few hours’ as stated by Dr. Fuks. Quite to the contrary, social accountability was seen as the overall way of serving the needs of individuals and communities and society at large. Mr. Doug Griffiths reminded participants that Canadians are attached to cultural icons and they are not easy to change, but historical examples show us that it is possible.

And finally, participants agreed that it is time for **action**. All participants were committed to action, and all recognized that while it would be challenging, it was time to move forward.

The Next Steps

Through a discussion at the end of the day, guided by Dr. T. Jock Murray, Symposium participants embraced a model for action with next steps.

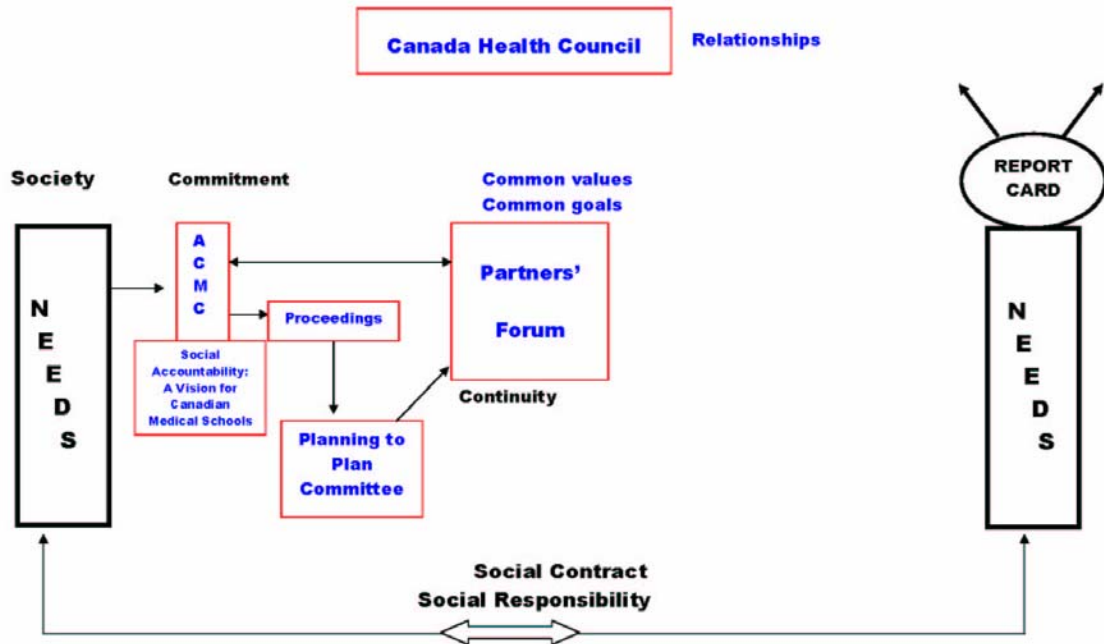
Figure 1



Throughout the Symposium, participants had voiced their recognition of societal needs and their commitment to addressing those needs in the most effective way possible.

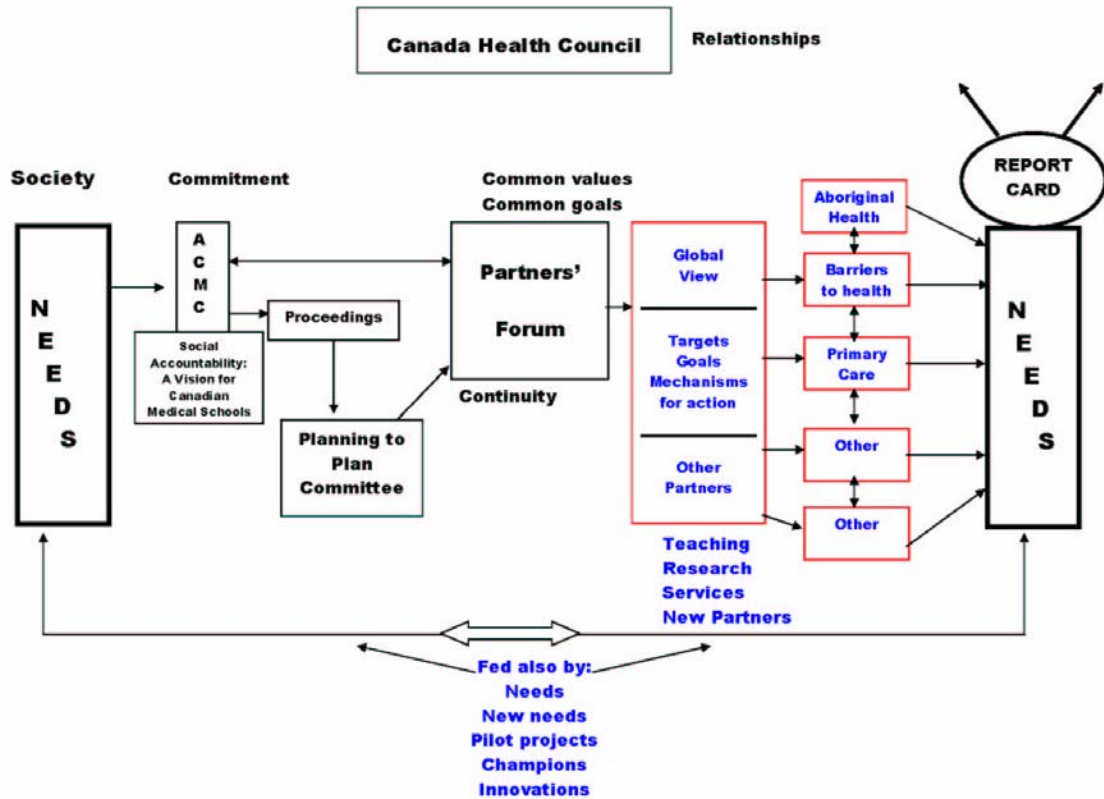
They saw that they had a social responsibility and were willing to enter into a social contract. This commitment had already been articulated in *Social Accountability: A Vision for Canadian Medical Schools*. They recognized that the identification of society's needs, and the commitment to social responsibility, led to action. This action is intended to influence those needs and in turn be influenced by those needs as they change. Therefore, the next critical question for participants was "what will the process be that will enable us to take action?"

Figure 2



Participants made a commitment to utilize the vision paper, and other similar reports produced by other partners, along with the proceedings from this Symposium and entrust a small 'Planning to Plan Committee' to formulate the immediate next steps. There was a clear recognition that all partners need to be fully engaged in the process if it is to succeed, and that this was not yet the case. Therefore, that Committee would embark on convening a Partners' Forum, and through that process identify who those partners need to be.

Figure 3



The Partners' Forum will be the place where partners will begin to articulate common goals and values, explore how relationships will develop and evolve, and begin to describe specific actions. The proposed Canada Health Council was seen as critical to the formation of partnerships. Specific projects might be developed but at the same time there should be a global view at all times.

"This is a brilliant formulation and distillation. It represents a response to the challenge that we all have in this room. If the fora already existed, if the mechanisms already existed, if the relationships already existed, we would not be here. If it was easy to do, someone would have figured it out a long time ago. We have wise and committed people in the room. We have wrestled the problem down to a general conceptual basis and now we need to take the next logical step which is to start to refine some next actions."

Dr. Robert Woollard

Proceedings

Introduction and Welcome

Robert Woollard

Royal Canadian Legion Professor and Head, Department of Family Practice,
University of British Columbia

Dr. Woollard welcomed Symposium participants and charged them with their task for the day. He recognized the diverse range of participants – a range that is so critically needed to accomplish the multifaceted tasks ahead.

“Collectively we represent a broad range of perspectives required to address the task we have mutually embarked upon. We represent the skills and perspectives needed to undertake the complex work that lies before us. We represent the public service, those willing to stand for public office, those devoted to being tomorrow’s doctors and those devoted to helping that to happen. We represent those devoted to a variety of serving professions who must work together at the coal face to support the health of Canadians, and those who have provided a voice to the voiceless to ensure that the institutions of our health system work in response to the needs of all.”

Dr. Woollard introduced the day with the definition of social accountability as outlined by the World Health Organization which is:

Social accountability of medical schools is the obligation to direct their education, research and service activities towards addressing the priority health concerns of the community, region, and/or nation they have a mandate to serve. The priority health concerns are to be identified jointly by governments, health care organizations, health professionals and the public.

He recognized the leadership that has been taken by the ACMC and Health Canada that has been so eloquently captured in their jointly published paper: *Social Accountability: A Vision for Medical Schools*. The support of Health Canada has been one of the essential features of this evolving partnership. In addition, the support of the Council of Ministers of Education, Canada has been crucial in forming linkages within the networks of government.

Dr. Woollard set out the challenge for the future *“to use the idea of social accountability to foment collaborative action by the people, perspectives and organizations represented within this room.”* In order to accomplish that, he outlined what the group had to do.

“We need to respect what each brings. We need to work together. While we have all worked together in other jurisdictions and circumstances, what is unique about our stated objective today is the bold attempt to link all of this laudable activity across all levels of government, across the lines of healing professions, across the lifelong spectrum of professional learning and along the bewildering

range of research so that the health needs of Canadians are addressed in the most effective and efficient ways possible. This objective is so important that if 'it' were easy it would already be done."

The Task of National Policy Making

Ian Shugart

Assistant Deputy Minister of Health, Health Canada

Mr. Shugart set the stage by identifying that over many decades Canada has built a high quality, technologically advanced health care system that provides health care to our citizens with two particular hallmarks – efficiency and a high degree of equity. Canadians are strongly attached to the system of health care that they have chosen. First Ministers have agreed on key concepts and concrete actions to preserve and strengthen that system. In the last three years, the policy and delivery debate around health care has focused particularly on issues of sustainability.

Mr. Shugart outlined the three main dimensions to policy making at the national level in health and provided examples of how they embrace the concepts of social accountability. Throughout his comments he stressed the concept of partnerships.

Policy making reflects national values. The job of national policy makers is not to capture every aspect of provincial policy and choices – but to capture national values. That is no better stated than in the Canada Health Act. *“The Canada Health Act is the most obvious representation of the social equity in the health system that guarantees access to medically necessary services on equal terms and conditions.”* National policy makers – when doing their work – come back to those important principles of “access on equal terms and conditions”. In the last Health Accord, policy makers have gone further on the principle of comparability and equity – they have made commitments to Canadians on health status, health outcomes and the performance of the health system. Mr. Shugart identified great potential for partnerships in the process of reporting to Canadians. For example: linking medical schools, measuring the performance of medical schools and contributing professional expertise.

Policy making focuses on the integration of jurisdictional responsibilities. Perhaps the most relevant example of this is the reaction to the current outbreak of severe acute respiratory syndrome (SARS). *“Over the last several days and weeks – due to SARS – we have seen playing out the collaboration of federal, provincial and municipal public health officials. There is a seamless web of interaction on the ground. That is fundamental to the health status that we enjoy.”* There are other examples of integration of the different responsibilities – disease prevention, health promotion and research. Research is a key field where alignment of the interests and needs of decision makers in the federal and provincial/territorial governments, with the capabilities of the academic health centres, can be balanced and need to be advanced. There needs to be particular focus on translating research and the knowledge so that it generates into policy and decision-making. Mr. Shugart pointed out that since health and health care is always unfinished business – so is collaboration. A pressing example – and one which needs to be embraced in the focus on social accountability – is the health of Aboriginal Canadians. *“That business has hardly begun. We have to collectively explore models of delivering service and getting our policy act together.”*

Finally, national policy making is based on economies of scale. Whether it is sharing best practice in primary care models or collaborating on the common drug review – part

of national level partnership is about using collective resources more efficiently. Many examples are currently underway – collaborating on the development of the electronic health record and addressing issues of patient safety. However, perhaps the best example is the urgent need for collaboration in health human resources. The new Federal/provincial/territorial Advisory Committee on Health Delivery and Human Resources is taking a needs based approach to health human resources planning “so that the health human resources that we build in the future will be better than what we have done in the past.”

“There is an echo in all of the elements of the Health Accord of the vision for medical schools for social accountability. We are not talking just about the production of health professionals, but how they are trained to support new flexible models of primary health care and how and where they are deployed throughout the system. This may be the most single most important arena for partnership between academic faculties of medicine and the other professional schools and policy makers at the provincial/territorial and federal level.”

The Task of Provincial Service Delivery

Thomas Ward

Deputy Minister of Health, Government of Nova Scotia

Dr. Ward continued the discussion by addressing how jurisdictions can move forward on the agenda of social accountability and focus on bridging the gap between the 'coal face' and the policy arena. He focused on a number of concepts that illustrate how social accountability can be integrated into provincial service delivery.

Beginning with a consideration of 'accountability', Dr. Ward addressed two important components of accountability – autonomy and empowerment.

He first spoke to the question, what is autonomy? *"I am clear that you are autonomous when you raise all of your own money – then you can spend it how you want to do it. Health care systems don't do this, nor do universities and public school systems."* Therefore, rather than a conversation about autonomy, provincial policy makers and providers in the system need to have a conversation about the framework that will empower the health care system to do the kinds of things that all parties can agree need to be done. This means that policy makers need to have frank discussions in their own ranks about giving up direct control. *"In my own department of health, I have made it clear I don't think we should be in the service delivery business – it's not our job, it is someone else who is part of the team."* Empowering an organization has many consequences – one of the most vital is that it enables them to become innovative.

Through the process of empowerment arises the need for accountability. *"When agreeing to give up control there has to be sense of accountability. That is part of the fabric of any government and how a bureaucracy works – there has to be some ability to follow decisions and to follow expenditures."*

Central to the concept of accountability is the need to report on performance indicators and goals for improvement. This requires information infrastructure. The Canada Health Infoway Inc. process has provided a good start. It will be important to move to outcome based indicators. We need better indicators of how we manage health and disease in the community and how we measure and improve the health of Canadians. New indicators are needed that measure progress towards those stated goals reflecting improvement and integration. Outcome is the result of a process that is owned by a team.

Dr. Ward cited the example of primary care. *"The conversation about primary care would be facilitated greatly if we stopped worrying about primary care being a program and thought about it as a process to improve the general health of the population. And if we recognized that many people have ownership – including school teachers, community based workers and others."*

Finally, Dr. Ward stressed that accountability is a combination of an enabler and a driver. It enables organizations to talk about new directions. And it drives organizations to get there – it is a motivator.

Dr. Ward concluded by articulating that social accountability is all about partnerships. He cited Peter Block's book "Stewardship" where the primary concept is one of putting service before self-interest. *"This is the type of book that public governing boards and policy makers should take time to read. The conversation we are having today is about public stewardship."* Central to stewardship are partnerships. Block declares that centralized control and paternalism in organizations must be replaced by genuine partnerships in which all are truly empowered and share full accountability. There are a number of basic requirements for these partnerships.

- The exchange of purpose – which is what the Symposium's deliberations are all about.
- Who is in charge? In a true partnership the partner in charge is there for clarity – clarity about direction, clarity about rules, never for control.
- The right to say no – in a true partnership you can say no and not lose your voice. On the other hand, when you are suppressed or oppressed then you are not really at the table. True partnerships enable people to participate and say what they think and at the end of the day they carry on.
- Joint accountability.
- Absolute honesty.
- And finally, when you enter into a partnership, abdication is not an option.

"The move to social accountability for all of us intuitively seems to be the right thing to do. It very clearly reflects our social values and beliefs. [What is important at this time] is the conversation of how we enhance those values and how we move forward."

A Framework for Action and Tools to Measure Progress

Charles Boelen

International Consultant (health system and personnel)

Former coordinator of the Program for Human Resources in Health, WHO

Dr. Boelen presented the Symposium participants with a framework for social accountability. His framework is based on certain crucial assumptions: that order is better than anarchy; altruism is better than self-interest; being explicit is better than being implicit; and peace is better than war.

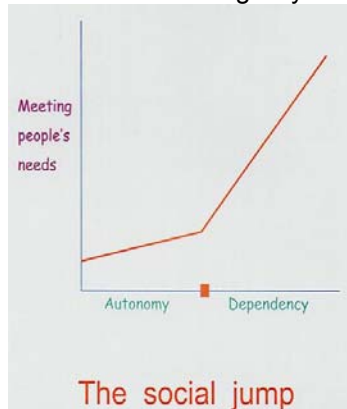


In order to create sustainable partnerships, the basis of social accountability necessitates agreeing on values. Dr. Boelen reminded the group about some fundamental values – quality, equity, relevance and cost-effectiveness. Every member of the partnership – be they caregivers, policy makers, academics, managers, citizens of the community – has something to contribute to those values. He provided us with some vivid examples for caregivers – but reminded us that these values apply to all.

- *As a caregiver if someone says to you, “there is something burning in my stomach” and you ask and listen further, you may learn that he has just lost his job and his wife has left him. If you consider those three elements of his life as one, you serve quality. If you simply say, “I will give you some antacids” – you do not serve quality, you violate quality.*
- *As a caregiver, if you say, “I care for everyone. There is no discrimination. I am willing to give services to anyone, whether they can pay or not pay”, you serve equity. If you say, “I serve the ones who knock on my door, I do the best I can. I have no time to care about the general population or the denominator” – you violate equity.*
- *If you say “priorities have to be adapted to local circumstances – everything is changing. There are more important things in certain areas at certain times, so my plan will adapt”, you serve the value of relevance. But if you say “what I do is good for everyone all of the time – let’s just go on with things”, you violate relevance.*

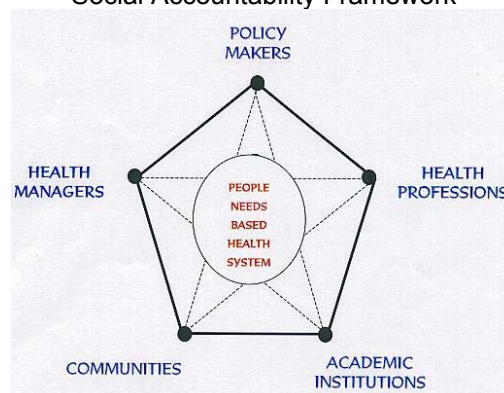
- If you say “there is a better way of using my resources, I can find alternatives to make the best use of the little resources I have”, you serve cost-effectiveness. If you just take it, saying “I need it, I am going to give it, whatever the cost”, you violate that value.

Beyond Rhetoric means moving Beyond Boundaries



Dr. Boelen reminded participants that “Beyond Rhetoric” was in the title of the ACMC/CAME Annual Meeting. Moving beyond rhetoric means going beyond all boundaries – adopting a team approach. This is central to sustainable partnerships. He presented a simple graph illustrating that it is possible to meet people’s needs to a certain level when remaining autonomous and working independently. However, working with others enables us to go much further in meeting people’s needs. “We are depending on others. We have to form alliances. So the partnership is absolutely an obligation – it is not an option. Once we do that we come closer to people’s needs and become more socially accountable.”

Social Accountability Framework



Boelen C, *Towards unity for health . Challenges and opportunities for partnership in health development*, 84 pages, World Health Organization, Geneva, Switzerland, 2000. Also available on the website of the organization "The Network Towards Unity for Health " www.the-networktufh.org.

Dr. Boelen provided a framework to help participants move towards some common goals. He emphasized the three elements of the framework – what is in the circle, what is on the tips of the pentagram, and the relationships between them. They present three challenges.

The first challenge relates to the organization of the health care system. The system and its services should be centered on the needs of individuals and the population – the circle in the middle. He pointed out that our system is not conducive to providing services in that fashion because it is fragmented. *“We have medicine here, we have public health here. We have preventive and curative. We have doctors and nurses, we have generalists and specialists, and we have public and private”*. What will bring people together is to agree on common views on health service delivery – views based on integration and a population health approach. This requires that information be shared in a better fashion – there is full transparency and all stakeholders are aware that power is shared.

The second challenge is institutional change. *“If the five partners honestly ask the question, “Am I organized and manage my affairs to serve the centre?” they would have to answer – not exactly.”* Dr. Boelen stressed that each of the partners has to ask “Am I contributing to the centre?” He cautioned that a medical practitioner who works in a private setting and in a fee for service system has difficulties being involved in public health programs and “caring for the denominator, not just the numerator”. And, if citizens ask for everything *“all of the time, quickly, with no waiting, for free”* – they are not being socially accountable. They have to share more of the burden of health care as well.

The third challenge is sustainable partnerships. “Can we work together, can we share resources, can we pool resources, can we listen to others, can we have a common language? And can we go beyond our opportunistic partnerships – and enter into sustainable partnerships that work in the long term”.

Dr. Boelen reminded the participants that this meeting is about action. Therefore, what are the next steps? He outlined four: action research; socially accountable partners; education for unity and policy formulation/development.

He stressed that it will be critical to bring the evidence about social accountability forward in order to convince ourselves and others that this is valid. This requires action research – including small, regional projects and larger national ones. Next, each partner needs to be introspective. *“The medical schools have started. We expect the medical profession to do that, the pharmacists to do that, in some countries the nurses are doing that”*. Each profession needs to ask itself “Are we socially accountable as a profession?” Next, we have to educate ourselves about creating unity and working together. *“We are quite ignorant about how to create unity. We are not educated about that. We do not have those paradigms in front of us. If you go through the schools of public health, health management and health policy there is very little about that.”* All partners need to learn skills – negotiating with others; learning each other’s strengths and weaknesses; learning to give and take; learning how to create synergies. This requires the creation of education programs – **from awareness raising workshops to longer integrated programs**. And finally, in a parallel fashion, it is important to move from good action – from people who have good intentions, from partners who have questioned their social accountability – up to a much higher policy level so that this action becomes long lasting and sustainable.

Dr. Boelen left the participants with an inspiring analogy in the form of a cartoon – the view of Québec City from the meeting hotel.

*“I found the view to be quite inspirational. What struck me most is the contrast between the bricks, the stones, the rocks – and everything else that is fluid – the water and the air. The Chateau Frontenac and then the St. Lawrence. There are things that we share among us that are solid and non-negotiable – like the Chateau Frontenac. For example, our **values** – these we cannot negotiate. We believe them and should begin to list them. Next, our directions. If we believe in these values, let us go in these directions. Each of the stakeholders has to agree on a **population approach**, they have to go beyond their patients; they have to have a wider view. They have to accept that it is important to have comprehensiveness in care, in health – that no one should interrupt the process of continuity of care. They need to agree that **everyone should contribute to and have access to information** – from the consumers to the policy makers and academic institutions.*

Then there are things that are less solid things – more fluid. Each stakeholder group may choose their different itineraries, and work through them in their own way. For example, medical schools may say that social accountability is so important that it must be part of accreditation. We will leave it to them to do that – the way to achieve that will be theirs. Another example, as all groups get involved and enter into a new social contract, each will have to determine their own course to accomplish this at their own speed.

Our values and directions are solid, our pathways may be more fluid but we will all end up at the same end – working in a sustainable partnership towards social accountability.”

The Challenges of Communicating Publicly on Health Reform

Douglas Griffiths

Member of the Legislative Assembly, Government of Alberta

Mr. Griffiths brought comments from The Honourable Gary Mar, Minister, Health and Wellness, Government of Alberta.

Mr. Griffiths identified that the changes involved in achieving social accountability are paramount to changes in cultural identity. While it may not be explicitly stated in that way, it affects the way we all see ourselves – and therefore is a cultural change. And he cautioned that we do not give up our cultural symbols easily – we identify with them, they are part of how we define our world. However, cultural change can and does happen. Mr. Griffiths gave the example of the introduction of the Canadian Flag. For many years, Canadians were very attached to the Red Ensign – it was a cultural icon. They did not give it up easily, but decades later the maple leaf has replaced that symbol.

Mr. Griffiths commented that current practice in medical schools has developed over the last 100 years – based in large part on Flexner’s report on medical education. That report introduced its own cultural change in medical education with concepts such as a solid scientific basis for education and decision-making and the use of university hospitals for clinical exposure. In his review of the Flexner report last year, Dr. Charles Boelen referred to the move to social accountability in medical schools as a new paradigm. *“After almost a century of practice, you are introducing a new vision. You are shifting the focus of the hospital-centered Flexner model to focusing on public priorities with standards and measures of achievement. I call that nothing less than a change of culture.”*

Mr. Griffiths described how health reform is analogous to the paradigm shift to social accountability in medical education. *“Health reform is much more than changing a system – it is a cultural change”*. And as such, he identified that one of the biggest challenges facing all of us is how we communicate with a public that sees health care as part of its Canadian identity.

Mr. Griffiths offered suggestions for meeting this communication challenge. *“I take some particular inspiration from that icon of 20th century cultural change – Al Capone. Al Capone is quoted widely as saying vote early and vote often. I would say that that applies to health reform communication – speak early and speak often. Speaking being a metaphor for all kinds of communication – print, internet, advertising, media relations, as well as the person-to-person speaking that we are doing at this symposium today.”* Speaking early is imperative because change creates insecurity, and the common outcome of insecurity is fear – but fear can be alleviated by information. *“Speaking early enough can make the difference between delivering a message that people will hear and one that they will resist.”*

Mr. Griffiths advised that speaking often means multiplying the message through partnerships. Minister Mar has met with all of the MLAs on health reform so that they would be better able to respond to their constituencies' concerns and needs. The Provincial Government appointed an independent health reform implementation team to be the public watch dog on health reform – including the Minister, physicians, nurses, economists, among others. The team's constructive criticism holds the government accountable for their actions. But the team's public progress report created another opportunity to create media and public interest in health reform and to speak again.

Mr. Griffiths shared another Alberta example of speaking early and speaking often related to health care reform. Prior to releasing the Mazenkowski report, the Alberta government released a tabloid style publication to all Albertans that gave them critical information about their health status and the health care system. This not only generated interest in the Mazenkowski report but it gave people information to let them judge the recommendations from that report themselves.

Mr. Griffiths, on behalf of Minister Mar, concluded by welcoming a vision for social accountability in Canadian Medical Schools. They supported the conclusion that 'Canadian medical schools are in a unique position and are prepared to play a major role in seeking to contribute to the sustainability of the health care system into the future.'

“We cannot underestimate Canadian’s attachment to health care as a Canadian icon. We identify with it. We identify ourselves as Canadians by it. But as much as our health system defines us we must also remember that we define our health system. We define it in how we deliver services and the kind of services we deliver. We define it in how we prepare our physicians and other professionals. We define it in our policy, our planning and our directions. These things are important, they are essential. But they are no more essential than working across sectors, across disciplines, and across jurisdictions to communicate publicly on the necessary and dynamic changes we must achieve.”

Work Group 1

Kendall Ho

Associate Dean and Director, CME, University of British Columbia

Question: Given challenges such as the geography of the country, its diverse cultures and variety of social issues, what do our marginalized populations (Aboriginal, poor, inner city, rural etc.) need from medicine? From health policy? From the Academy?

The group began by modifying the question. They decided to look at all populations – including marginalized populations. Next, they considered the word ‘need’. They replaced it with the concept of interdependence – whereby society has certain needs that providers, academics, etc. can address. They too have a great deal to learn from society and the population. Finally they reversed the question to ask “How do individual partners bring strength and clarity to the team?”

First, and perhaps most importantly, the group identified a number of values that the team shares.

- Responsiveness to team members.
- Expertise and competence.
- Giving voice to the community.
- Commitment to the team and mutual empowerment in the work.

Looking at health professionals, including all professionals and the Academy in a united way – the group answered the question “What strength and clarity do they bring to the team?”

- Training
- Health research.
- Advocacy for individuals – having the information and knowledge to be able to advocate for individuals.
- The trainees – the residents, medical students. They are transforming from community to health care professionals, bringing unique ideas and perspectives.
- Many health professionals are embedded in the community and understand the issues intrinsically.

Regarding health and social policy makers and health administrators – the group answered the question, “What strength and clarity do they bring to the team?”

- The ability to analyse the global needs of the partners.
- The ability to ask questions about the system – system advocacy.
- The ability to follow through on the innovation and influence directions.
- Demonstrating commitment to the analysis and the research.

Considering the community – the group answered the question, “What strength and clarity does the community bring to the team?”

They identify the needs.

- They have significant power.
- The power of self-determination.
- The power to influence public opinion.

- The power to lead community reform.
- The power to demand integration of services in the community.

Finally, the group also identified many shared team functions.

- Targeted recruitment and training.
- Cultural competence.
- Total cost accountability of the system. Each partner carries privileges and responsibilities.
- Structured connectedness – not only bringing to the table but how do we structure our connectedness to bring this.
- And also bringing balance – for example, translational research versus curiosity research.

Work Group 2

Carl Whiteside

Associate Professor, Dept. of Family Practice, University of British Columbia

Question: How do current patterns of training, research, health policy and models of care address community needs?

The group concluded that the five players involved – academic institutions, health professions, community, policy makers, and health administrators – are moving towards the common goal – appropriate health for all. We should be optimistic about this! However, it appears that groups have been working from different “streams” as illustrated in Dr Boelen’s art work. The common deficit of all the players is lack of communication and coordination.

The group focused largely on academic issues. Thus examples used by the participants were mainly academic. However, it became clear that the core issues are common to all streams.

The examples given indicate a trend in some medical schools towards considering social accountability.

- Evidence of social accountability is occasionally being considered when selecting new faculty.
- Characteristics of social accountability are, in some schools, being considered in the student selection process.
- Some schools are increasing curricular content and evaluation of the acquisition of knowledge in the area of social accountability.
- There is movement towards research based on principles of social accountability. However, there is a perceived tension between ‘personal curiosity research’ and ‘socially responsible research’.

Other issues were identified as being more problematic.

- Rewards for social accountability have not made it into the academic promotion and tenure system. Movement towards promotion based on social accountability would go a long way to move the agenda forward.
- Leadership issues are critical. It will be essential to select leaders who are committed to and have demonstrated leadership in social accountability.
- While communication is a major problem amongst the major players, communication problems also exist within the academic environment (intra, and interdisciplinary).
- Curricular content and training models need to be focused towards addressing the “priority” health needs of the communities we serve.
- Movement towards new models of collaborative interprofessional community – based educational initiatives will contribute to improved health care outcomes – thus, the social accountability agenda.

The group concluded that:

- There is some evidence of progress towards social accountability within each of the streams – the “partnership pentagram”.
- There are some examples of creative strategies that are bringing some of the players together.
- Each player needs to address common issues within their own stream.
- Within each stream common issues need to be addressed.
 1. Clarifying the vision of social accountability.
 2. Selecting leaders who understand this vision.
 3. Promoting and recognizing those who support the vision.
 4. Selecting learners within the stream who have social accountability characteristics.
 5. Training of these students in experientially-based, community-based models where the problems reflect reality.
 6. Curricular and evaluation reform that reflects social accountability.
 7. Focussing research on identifying the priority health needs of the community.
 8. Communicating between the different disciplines within each of the streams.
 9. Agreement and implementation of appropriate service delivery models.
 10. Funding policies that contribute to achieving the social accountability agenda.

Once the different players (streams) have addressed these and other issues, then all can move towards the mouth of the river to work effectively together to achieve “health for all”. This could possibly occur through a national health council with provincial sub-groups.

Work Group 3

Oscar Casiro

Associate Dean, UGME, University of Manitoba

Question: What current gaps can be narrowed through creative partnerships between the Academy, communities, policy makers and practitioners?

The group identified and discussed a number of gaps – they presented a couple that they considered most crucial.

One of the most pressing gaps is the one that exists between values and rewards. It exists at all levels – in education, research, and practice. For example, the mentor who is recognized by his students but is not recognized explicitly or formally by the school or university in promotion or tenure. Another example is the practitioner in the community who accepts residents but is not recognized by the university or the faculty. If social accountability is to move forward, students will need role models who have explicit recognition within the system and are not marginalized by it. It is critical to align the expectations with the reward system.

A second pressing gap is the one between wants and needs – again identified at all levels – students, trainees, researchers and practitioners. While it is critical to involve the community, at the same time it is important to be aware that certain gaps are perpetuated by community expectations and priorities (e.g., having their own hospital or their own MRI scanner). All partners need to work with public expectations so that they are meaningful.

The group felt that the solutions which would help to close these gaps will involve ‘percolating up’ as well as ‘percolating down’. ‘Percolating down’ means that leadership at all levels will adopt values of social accountability. As a result, the partnerships and strategies will embrace these values. ‘Percolating up’ will involve investing in and fostering best practices in interdisciplinary teaching, research and practice. This will begin with small examples – successful projects that will demonstrate the embracing of social accountability values.

“We are approaching times when leaders will have to make very tough decisions. It will be critical that the community be involved in all aspects of training, research and health policy. It will be important to remember that in order to effect real change, there is a need to invest and not just look at finding more efficiencies within the current system.”

Work Group 4

Robert Woollard

Royal Canadian Legion Professor and Head, Department of Family Practice,
University of British Columbia

Question: How can collaboration between policy makers, health professionals, academic institutions, communities and health managers be improved and/or made explicit?

The group focused on moving things forward – to action. They challenged the Symposium participants with the question, “How do we get there from here?” To start, they recommended an integrated strategy of collaboration involving the community. *“This will not happen by accident”*. They identified the need to build a system, but the challenge remains “How do we build the infrastructure to support this system?” Both bottom-up and top-down approaches will be required.

The group stressed that the strategy must begin with an affirmation of the positive. *“This is social change. And, we have to believe it is possible.”* The values have been, and are being defined – the group emphasized that it is time to move beyond rhetoric to action. First, the values must be communicated. Next, all players have “social accountability” as part of their mission and vision. At the other end it needs to be measured – e.g., in accreditation.

Two important strategies were identified by the group. The first is to identify projects which can provide the grounds on which to extract lessons. A starting point might be to focus on primary care for populations that are not well served at the present time.

Second, it will be critical to develop rich networks at various levels. These networks must involve champions of social accountability who are supported and enabled to share success and the conditions for success. The work of these networks will be to build a collective vision and act upon it.

The group saw the evolution of the announced Canada Health Council as an excellent opportunity to foster these linkages and networks. It could enable people to better define the federal or national role in linking a ‘network of networks’.

The group voiced cautions. All participants are living in times of rapid change – the political world is changing, people change often – at all levels – and there are changes in education and practice. Within this change, “we have to be careful not to depict ourselves as the *custodians of virtue* or speak on behalf of the community as their *custodians of virtue*.” Furthermore, in a rich partnership there has to be the kind of continuity that the current political process does not always provide. That will be the challenge as the groups leave the symposium – **to develop ongoing partnerships that are based on a common purpose and common values which are expressed collaboratively.**

What the Community Needs From its Professional, Academic and Political Partners

Minister Sharon Carstairs
Senate of Canada

Minister Carstairs provided participants with an overview of palliative and end-of-life care as a relevant focus – as an area unto itself, but also as an example of the need for collaboration and social responsibility and ultimately accountability in health care.

She challenged the group to “*expand our perception of social accountability in health care so that we regard it as our collective social obligation to extend health care over the entire course of an individual’s lifetime.*” She presented palliative care as an ideal example in health care that by its very definition requires partnerships, collaboration and cooperation from all interested parties which is paramount to social accountability. Palliative care is complex and requires innovative approaches. It encompasses divergent issues, different facets of health care and multiple approaches to patient care. It relies on contributions from different groups – the federal/ provincial/territorial governments, physicians, nurses, social workers, spiritual leaders, universities, community leaders, researchers, and the business community.

When addressing the question, “what does the community need from its political partners”, Minister Carstairs reminded participants that Canadians often look to their governments for setting an agenda for health care. She stated that the federal government is an important leader in setting national expectations for health care. “*It is the federal government’s responsibility to articulate minimum standards in the field of health, oversee their implementation – including verifying that established priorities are properly funded.*” Using the example of palliative care, the government can provide and has provided benefits for the people at the end stage of life and their families. It has provided tax measures to support Canadians at the end stages of their lives and their caregivers. It is working with the provinces to incorporate home care as a fundamental aspect of the health care system. It is encouraging national standards in palliative and end-of-life care so that they are the same across all provinces/territories. Minister Carstairs shared a number of examples of how the Federal Government has responded to the community with their most recent Speech from the Throne and budget.

- Financial investments to renew Canada’s health care system, aimed at improving the quality and accessibility of health care, including \$16 billion dollars transferred to the provinces and territories for a new Health Reform Fund targeted to primary health care, catastrophic drug coverage and home care (which includes long term, acute home care, community mental health care and end-of-life care).
- The development of a core set of minimum services that will be provided under the new Health Reform Fund and these will be determined with the provinces and territories by September 30, 2003.
- The establishment of a Secretariat on Palliative and End-of-Life Care in Health Canada. The implementation of a Canadian strategy for palliative and end-of-life care leading to the formation of a coordinating Committee and five working

groups in the areas of best practices and quality care, public information and education, education for formal caregivers, research and surveillance.

- A new employment insurance benefit for compassionate care leave for people to take time off from their jobs to care for a gravely ill or dying family member.
- Complementary tax measures for persons with disabilities and caregivers.
- The creation of a new Canada Health Council which will be charged with coordinating the health care objectives of the federal/provincial/territorial governments.

Minister Carstairs also highlighted the importance of the academic community. She noted a critical need for more research in palliative care and the role that academics play in this regard. *“The work of researchers is key in providing proper end-of-life care to communities in Canada and must be one of the strategies that we move forward on.”* The federal government has become a partner in this research through the Canadian Institutes of Health Research.

And finally, Minister Carstairs identified that the community needs professional partners.

“Increased education and better qualifications in the field of end-of-life care are essential. The education and training of health care professionals is paramount if we are to improve quality of care”

What Provincial Ministers Need and What They Bring to the Partnership

The Honourable Dennis Furlong

Minister of Education, Government of New Brunswick

Former Minister of Health, Government of New Brunswick

Minster Furlong began by reminding participants that Canada has an exemplary health care system — *“if not the best in the world. Can it be made better – yes, that is why we are here today. Can it become less than what it is – beyond a doubt. If we don’t take care of it, it may not be there in the future.”* Minister Furlong stated that *“We have a good system. We are not in crisis, We are evolving. And we are dealing with issues as we go.”*

He cautioned that perspective is very important and that perspectives vary among groups. He challenged the group that while there was a great deal of background and knowledge among the symposium participants, the perspectives in the room are actually relatively narrow especially when compared with the broad range of perspectives that he meets among the Canadian public as a politician.

What do provincial Ministers need? Clearly they need resources that are consistent with demand – both financial and human resources. However, that demand for financial and human resources needs to be consistent with the reality and the burden of illness that we have in Canada.

Minister Furlong identified a number of challenges provincial Ministers and Ministries face when doing their jobs. Information and data collection pose a significant problem in governments. Dr. Furlong cautioned that while we collect a great deal of data, we do not collate, analyze it or move it into action very well.

There is a lack of standardized health policy across Canada. *“We have thirteen systems that are not on the same wavelength at the same time let alone on the same wavelength with the federal government”.* While officials in all departments across Canada work well together, politicians do not. Furthermore, there is a lack of continuity and consistency at the political level.

There is a pressing need for a national plan for health human resources. Since the products produced from the system – trained professionals – take 12 to 14 years to deliver, long term planning is critical. Someone needs to take ownership of this plan. Dr. Furlong suggested that ACMC, the Council of Ministers of Education, Canada and Health Canada are well placed to do so.

Primary care reform is a challenge. Minister Furlong affirmed that a national strategy, consensus on definition and innovation are all critical. As well, determining who will do primary care is very important. *“I am not sure what primary care is now. I am not sure who should be doing it and I am not sure who wants to do it.”*

There needs to be accountability. *“We need a reality check about the sustainability and cost because we cannot afford every policy we would like to have.”*

What do Ministers bring to the partnership? Minister Furlong recommended that they have to bring consensus – they have to work together towards common goals. In order to achieve that consensus they have to communicate with each other and listen. They have to communicate with the community and they have to listen. They have to communicate with providers and they have to listen.

“We have to have a national forum where policy can be generated by governments. Like it or not, governments and politicians make policy in this country and we have to get our messages out there for the betterment of all the people. If we don’t do it, who will?”

What Practicing Physicians Need and What They Bring to the Partnership

Dana Hanson

President, Canadian Medical Association

Dr. Hanson put forward a challenge to the group that we must change the ways in which we deliver and undertake health care in Canada. He used SARS as an example making it clear that health professionals and governments must do things differently. He cited Alan Bernstein, the President of the CIHR, who said we are on the verge of our fourth revolution – the biological revolution – much as our ancestors and parents faced the agricultural, industrial and most recently the information revolution. This biological revolution will in turn lead to a therapeutic revolution where hopefully in the next 20 years, we will see patients treated with regimes of gene-based designer drugs and a shift in medicine from cure to prevention. That revolution won't come cheaply. However, it will present a real long-term sustainability challenge for all of us.

Dr. Hanson saw the First Ministers' 2003 Health Accord as a tremendous potential for a renewed health system in Canada. However, he cautioned that before we realize that potential, Canadians, particularly those in the health and health care systems, will need to work in partnerships with each other.

He defined partnerships by explaining what they are not. Partnerships are not about taking somebody else's money, nor becoming absorbed with someone else's mandate. A true partnership stems from parties agreeing upon a common goal – a destination. For physicians, that means more mutually respectful relationships with governments. Physicians bring a reality check in terms of experience in the actual health system to any debate of that system. They also bring credibility and a strong commitment to making a good system even better.

Dr. Hanson stated that in order to truly realize the potential of the First Ministers' Accord, the Canada Health Council will be the key that will make the necessary partnerships work. It will be the joint body that compels the provincial/territorial and federal governments to work together. The Health Council has the potential to return ownership of the Canadian health system to Canadians – making it more accountable and transparent to the people who own it. He cited five principles that will enable the Council to serve Canadians effectively. They are:

- *Legitimacy – protecting the interests of Canadians and keeping those interests balanced.*
- *Independence – being an arm's length advisory agency.*
- *Transparency – being open and answerable to Canadian tax payers – reporting annually on the health system's performance and the population's health status.*
- *Credibility – representing a broad range of perspectives and expertise, and equally representing patient and non-health sectors, health care providers and managers, and governments.*
- *Permanency – having the financial and human resources to do its job properly. "It must not be a paper tiger."*

Dr. Hanson described what the health care system will look like a few years down the road if the Health Council is effectively implemented.

“The Canada Health Council will help build a system that puts the voices of physicians, nurses, other health care providers and Canadians at the table when decisions affecting our health system are being made. It will help ensure accountability and transparency. It will enable governments to work together to modernize and expand our health system. It will help speed up reform. It will provide a forum in which experts representing a wide range of sectors in Canada – health care, government and public – can collaborate and provide policy guidance at arm’s length to governments. As a permanent and properly funded body, it will help ensure that our health system continues to grow to meet the needs of Canadians well into the future. And finally, and most important, it will put the health system back in the hands of its owners – Canadians.”

What a Socially Responsible Academy Needs and What It Brings to the Partnership

Abraham Fuks

Dean, Faculty of Medicine, McGill University
 President, Association of Canadian Medical Colleges

What does the academy bring to the table? Dr. Fuks identified that the Academy trains health professionals, develops concepts, i.e., does research, and provides and disseminates new technologies. He defined the Academy to include schools of medicine, rehabilitation science, nursing and the affiliated teaching hospitals. Dr. Fuks stressed that social accountability cannot be an ‘add-on’ to the Academy. It is not a program, it is not a course, and it is not simply worth “three credits”. It must be harmonized into education, research and clinical care.

He also cautioned that participants must not lose sight of the individual patient – particularly when educating students. While it is true that there must be consideration of the community and the public, he stressed:

“I suggest that we must not lose the person. We cannot run off in one direction and forget about where we came from. Particularly at the educational level, the individual is important. I would submit that social accountability begins at the bedside and in the clinic.”

With regard to research, Dr. Fuks warned participants of a false dichotomy – that basic research is curiosity driven and population research is not. He stressed that all phases of research, molecular through to population, are socially responsive and reactive to the environment in which investigators find themselves.

What does the Academy need? There are many issues facing the Academy and these are having an influence on its needs. There are many potential solutions. However, Dr. Fuks’ main message in addressing all of these issues was “*We can’t do it alone*”.

<i>What are the issues/needs facing the academy?</i>	<i>What are the gaps and solutions?</i>
Physicians as advisors	Insufficient time per patient
High tech interventions	Limited resources
Integration of care	Models lacking
Continuity of care	Information systems/models

The patients are changing. Demographically they are and will be older. In addition to the unwell elderly, there will be an increasing population of what Dr. Fuks described as the ‘fragile, but well, elderly’ who will need a different kind of medical care. Patients have a consumerist mind set – they are educated, with high expectations – and they have access to a great deal of information, such as the internet – which Dr. Fuks described as both good and bad – the ‘Sargasso Sea of data’. Patients are increasingly turning to providers of complementary and alternative medicine. Why? Dr. Fuks

speculates that it is an indication that *“we are doing something wrong. What the complementary healer does is give the patient what we don’t, and that is time.”* Changing this will require different models of care, different funding models and a different culture of care. *“We can’t do that alone – we need the professional associations and governments to work with us. All of the solutions are based in partnerships.”*

There are shortages of personnel – of health care professionals, of specialists and of primary care physicians. The professionals are facing challenges to their quality of life. Patients and physicians alike are living with fragmentation of care or “stroboscopic medicine”. This is not only at the level of the community, as pointed out by Dr. Boelen, but also for the individual. Patients have become the syndicators of their own care.

What does that mean for medical schools – those who teach? The academies are struggling to develop a more integrated model of medicine and medical teaching where professionalism and healing are again part of curriculum. *“You cannot have a single course on professionalism any more than you can have a module on social accountability. They are cultural perspectives.”* There is a need for better continuity of care models for trainees. There is also a need for multi-professional education but Dr. Fuks cautioned that it is not easy to implement. There is a need to market the academies’ role to its constituents – students, governments and professional associations.

Dr. Fuks pointed out that we live in an era of burgeoning high tech interventions and the tendency has been to expect to use it all. However, he warned that as the resources are limited – as they cannot help but be – we have to figure out how to distribute them. This will involve talking with patients in the community – having a meaningful dialogue – partnerships.

“There is not a single aspect of the solution that the Academy can undertake alone. However, it is not only concepts of partnerships that are needed, but actual mechanisms. I think that we can do it. These are all exciting things. These are the challenges to the Academy. I do believe with the appropriate mechanisms of partnership, all those things are achievable. If we can achieve those goals, we will really have a socially responsive and a socially responsible academy.”

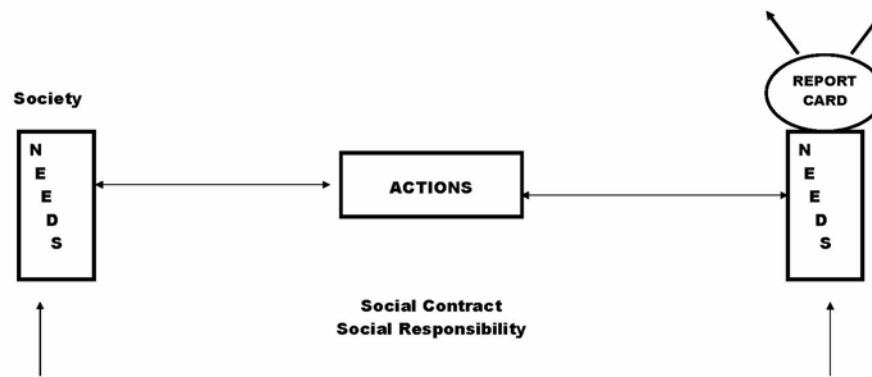
Closing Plenary: Summary and Next Steps in Partnership Building

Jock Murray

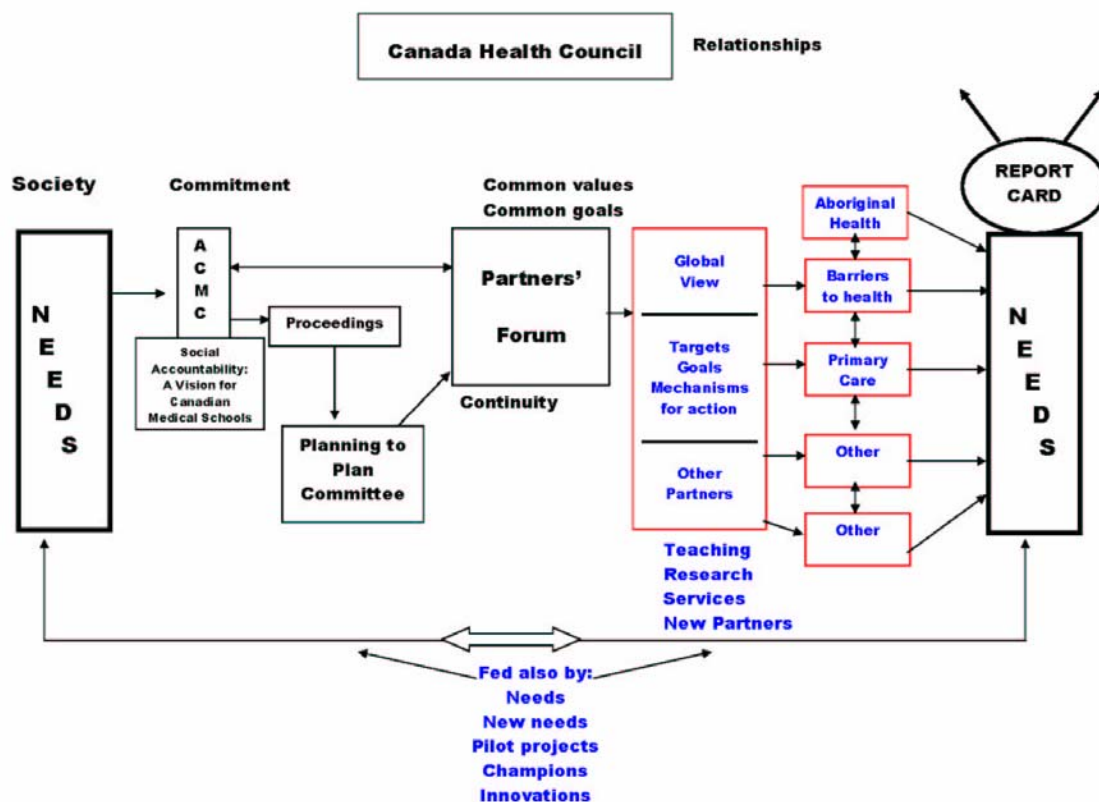
Director/Professor of Medical Humanities
Dalhousie University

Dr. Murray began by reviewing what participants heard over the course of the day.

- Participants are clearly committed to social accountability.
- Saw the social responsibility of their institutions as a collectivity.
- Saw the formation of partnerships as central to moving forward.
- Know it is important for partners to identify common values and common goals.
- Perceived that there are societal needs that need to be addressed.
- Want to take action.
- Want to be able to measure those actions and see that they have had an impact.
- Want to take a global view, take global action – but concurrently move on smaller ‘project type’ actions.



Dr. Murray acknowledged that the group had already committed to a social contract – the document, *Social Accountability: A Vision for Canadian Medical Schools* articulates that commitment. This vision paper identifies that there is a responsibility to address the needs of society. What is needed now is the action to accomplish this. Dr. Murray depicted the process in the above figure with the identification of societal need, the commitment to a social contract, action, reporting, and feedback to the process. “We will develop a process that some how takes action, measures itself and then can re-address. The question is: how are we going to do it?”



Dr. Murray suggested that the group was discussing a concept of a partnership to enact the process – bringing together the partners who can make it happen and committing to a concept on which all can agree. It will be important to identify who the essential partners are – it was generally agreed that they were not all present in the room. In order to achieve that, he recommended that a “Planning to Plan” Committee be struck – this Committee is tasked with identifying other partners and planning a forum where they could gather. This group is not going to decide what the answer is; it is going to *plan to plan* so that there is an iterative process that comes back. The process will be decided from there. Again, Dr. Murray re-iterated that in doing this the group not only selected ‘ideas’ but the symposium heard a lot about specific things that could be done. Rather the group needs to take a global view of what the societal needs are so that something is done. There is a sense of where it fits in the context of society’s needs. In order to facilitate that, relationships with the proposed Canada Health Council were seen as critical. At the same time, there could be specific ideas that could be acted upon – perhaps there could be two parallel processes going on – one being project driven and the other a plan of how social accountability will move forward. Proposals have been submitted to the Primary Care Health Transition Fund which could be part of the ‘project’ part of the equation. These proposals look at urban marginalized populations, including Aboriginal populations, continuing professional development, and Francophone minority populations outside of Québec.

In closing, Dr. Woollard thanked the participants and recognized the significant progress that was made during the day.

“We have identified a response to the challenge that we all have in this room. If the fora already existed, if the mechanisms already existed, if the relationships already existed, we would not be here. If it was easy to do, someone would have figured it out a long time ago. We have wise and committed people in the room. We have wrestled the problem down to a general conceptual basis and now we need to take the next logical step which is to start to refine some next actions.”

Participants

Dr. Evan Adams	Aboriginal Family Medicine University of British Columbia
Dr. William Albritton	Dean of Medicine University of Saskatchewan
Dr. Michel Baron	Dean, Faculty of Medicine Université de Sherbrooke
Ms. Jan Benedict	Canadian Federation of Medical Students
Dr. Mark Bisby	Vice-President, Research Canadian Institutes of Health Information
Dr. Charles Bolen	International Consultant (health system and personnel) Former coordinator of the Program for Human Resources in Health, WHO
Dr. M. Ian Bowmer	Dean of Medicine Memorial University of Newfoundland
Dr. Michel Brazeau	Chief Executive Officer Royal College of Physicians and Surgeons of Canada
Mr. Glenn Brimacombe	Chief Executive Officer Association of Canadian Academic Healthcare Organizations
Dr. Robert Burns	Federation of Medical Licensing Authorities of Canada
Dr. Paul Cappon	Director General Council of Ministers of Education Canada
Minister Sharon Carstairs	Senate of Canada
Dr. Oscar Casiro	Associate Dean, UGME University of Manitoba
Mr. Frank Cesa	A/Senior consultant on Physician Human Resource Issues Health Human Resource Strategies and Communication Branch, Health Canada
Dr. James Clarke	President Canadian Association of Internes and Residents
Ms. Clémence Dallaire	Canadian Association of Schools of Nursing
Dr. Dale Dauphinee	Executive Director Medical Council of Canada
Dr. Pierre Durand	Dean, Faculty of Medicine Université Laval
Dr. Jean-Paul Fortin	Canadian Public Health Association

Dr. Abraham Fuks	Dean, Faculty of Medicine, McGill University & President, Association of Canadian Medical Colleges
The Honourable Dennis Furlong	Minister of Education Government of New Brunswick
Dr. Grant Gall	Dean of Medicine University of Calgary
Dr. Yves Gariépy	Canadian Pharmacists Association
Dr. George Goldsand	Senior Advisor for Postgraduate Medical Education Faculty of Medicine and Dentistry, University of Alberta
Dr. Paul Grand'Maison	Vice-Dean, UGME and Vice-Dean to the Community Université de Sherbrooke
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Dr. John Millar	Vice-President Canadian Institute of Health Information
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